Summary of the Key Provisions in the Medicare Final Rule on the 2015 Physician Fee Schedule

Sustainable Growth Rate (SGR) Formula and 2015 Medicare Conversion Factor

Congressional intervention to avert a double digit cut to physician reimbursement means that the 2014 conversion factor of $35.8013 will remain in place through March 31, 2015. Absent further Congressional action to repeal the SGR formula or once again override the SGR and stop the double-digit cuts (as it has done for over 10 years), the conversion factor will drop to $28.2239, a 21.2 percent drop in physician reimbursement, beginning April 1, 2015. CMS reports that "the Administration supports legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care."

Physician Quality Reporting System (PQRS)

CMS finalized a number of requirements relating to the Physician Quality Reporting System. The PQRS is a group of quality measures that physicians must report on when they file claims for the Medicare patients to whom the specific measures apply. Starting in 2015, CMS expects physicians to report on at least nine measures across three of the six established domains (see chart below).

The PQRS includes the following reporting mechanisms: claims; qualified registry; EHR (including direct EHR products and EHR data submission vendor products); the Group Practice Reporting Option (GPRO) web interface; certified survey vendors, for the CAHPS for PQRS survey measures; and QCDR. Only one submission method may be used for all measures reporting. CMS made some changes to the reporting mechanisms, but did not modify the claims-based option most likely to be used by psychiatrists who are not aligned with a facility or large group practice. (See table below for details)

Measures

CMS ignored APA's request to maintain a number of the 2014 measures, effectively reducing the limited number of measures likely to be used by a psychiatrists. The chart below reflects some of the measures available for claims-based reporting that are relevant to psychiatry.

PQRS Measure Number	Measure Title	NQS Domain
046	Medication Reconciliation	Patient Safety
047	Care Plan	Communication and Care Coordination
110	Preventive Care and Screening: Influenza Immunization	Community/Population Health
111	Pneumonia Vaccination Status for Older Adults	Community/Population Health
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up Plan	Community/Population Health
130	Documentation of Current Medications in the Medical Record	Patient Safety

182	Functional Outcome Assessment	Communication and Care Coordination
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Community/Population Health
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow Up Documented	Community/Population Health
134 (considered a cross-cutting measure)	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Community/Population Health

A complete list of PQRS measures for all reporting mechanisms can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html (under "2015 PQRS Individual Claims Registry Measure Specification Supporting Documents")

Payment implications

The PQRS initially offered incentives for successful reporting, but these will no longer be in place for 2015. The penalty system in place for failure to report, which begins in 2015, is based on how the physician met the PQRS requirements 2 years prior to the penalty year. Hence, the 2015 penalty will be levied based on 2013 measure reporting (for that year only one measure had to be reported for one patient), but is applied to all Medicare reimbursement in 2015; any 2016 penalty will be based on 2014 reporting, and so on. For 2015 the payment adjustment, or penalty for failure to comply with PQRS reporting requirements will be -1.5%, applied to all of a physician's Medicare Part B reimbursements. The table below shows the reporting requirements by year and the associated penalties that will occur two years later.

Reporting Year	Number of Measures*and Patients**	Penalty	Year Penalty is Applied to Payment
2013	At least 1 measure for 1 patient	-1.5%	2015
2014	At least 3 measures for 50% of your eligible patients	-2%	2016
2015	At least 9 measures across 3 domains for 50% of your eligible patients	-2%	2017

*There is a Measure Applicability Validation (MAV) process available to determine if failure to meet the requirements was caused by an insufficient number of measures relevant to the physician's caseload. If this is the case, the penalty will not be levied. However, the MAV is new for 2015 and it is unclear how it will actually play out.

**Patients for whom the measures were applicable

Beginning in 2015 every physician who sees at least one Medicare patient for a face-to-face service must report on at least one measure from a new cross-cutting measure set in addition to the requirements listed above. We will provide a list of cross-cutting measures once they are available from CMS.

PQRS reporting is one of the variables that will be used to calculate the Value Modifier (VM) discussed below. If a Medicare provider fails to comply with the requirements of the PQRS, this will be one factor in determining a possible further diminution of Medicare reimbursements.

The Value-Based Payment Modifier and Physician Feedback Program

In 2010, as part of the Affordable Care Act (ACA), Medicare was required to establish a value-based payment modifier, or Value Modifier (VM), to enable differential payment under the Medicare Physician Fee Schedule (PFS) based upon the quality of care provided compared to the cost of that care during a set performance period. The statute requires the Value Modifier to be budget neutral, which means that any increase in payments to high performing provider or provider group must be equal to the reduction in payments to low performers. The Value Modifier, will be applied using a formula based on quality data (determined in part by PQRS reporting) and cost data, which is based on a beneficiary's use of the Medicare program. How the cost of the beneficiary's care is attributed to a provider or group of providers is based on a defined formula. The value rating, which determines whether a provider or group will receive a bonus or a penalty, is based on comparing that practice with others within the same size classification.

Some Specifics About the Future of the VM in the Final Rule

- The downward adjustment will be a maximum of -2% under the VM for groups 2-9 and solo practitioners that are in Category 2. Category 1 includes: solo practitioners who meet the criteria for satisfactory reporting of data on PQRS-qualified measures as individual for the CY 2017 PQRS payment adjustment, or, in lieu of satisfactory reporting, satisfactorily participate in a PQRS-qualified clinical data registry for the CY 2017 PQRS payment adjustment. Category 2 includes groups and solo practitioners that do not fall within Category 1.
- The VM will be applied to non-physician eligible professionals staring in 2018.
- The maximum amount of payment at risk under the VM is increased from 2.0% in CY 2016 to 4.0% in CY 2017 for groups of 10 or more eligible providers.

Quality Tiering

Quality tiering is what the analysis is called that is used to determine the VM, which will determine the nature of the reimbursement adjustment (upward, downward, or neutral) and the percentage of that adjustment. The tiering is based on both quality of performance (derived from the PQRS) and cost measures, derived from the cost of a beneficiary's care as attributed to a group or individual physician. Quality tiering will determine if a practice's performance is statistically better, equal to, or worse than the national mean (see table below). In 2017, the first year the Value Modifier will be used, groups of 2-9 and solo practitioners are held harmless from downward adjustment.

2017 Proposed VM Adjustments Based on Quality Tiering Cost/Quality	**Low quality**	**Average quality**	**High quality**
Low cost	0	+2	+4
Average cost	-2	0	+2
High cost	-4	-2	0

Quality Resource Use Report (QRUR)

The QRUR is a feedback document issued by CMS that providers can use to determine how they compare to their peers. CMS believes that the QRUR will give providers the opportunity to "take action" and make necessary corrections based on the information they receive. The QRURs preview information about an individual or group's quality and cost performance rates for the VM. CMS recently mailed out QRURs based on care provided in 2013 to all groups and solo practitioners. These 2013 QRURs display a practice's quality and cost composite scores, which are used to calculate the VM. For a group practice of 100 or more eligible professionals that elected quality tiering, the 2013 QRUR displays the group's 2015 Value Modifier payment adjustment. The QRUR establishes quality and cost performance based on the Quality Composite Score.

- Quality Composite Score
  The Quality Composite score summarizes a medical group practice's performance on quality indicators across up to all six of the equally weighted quality domains in the PQRS (Clinical Processes/Effectiveness, Patient and Family Engagement, Population/Public Health, Patient Safety, Care Coordination, and Efficient Use of Healthcare Resources). Standardized scores reflect how much a group's performance differs from the national mean performance on a measure-by-measure basis.

  A quality composite score of +1 or higher places the provider in the "high quality" tier. A score of -1.0 or lower places the provider in the low quality tier.
  The same methodology will be used in 2016 for groups of 10-99, and in 2017 for all groups and solo providers.

- Cost Composite Score
  The Cost Composite Score summarizes a medical practice's performance on costs across two equally weighted cost domains: 1.) Per capita costs for all attributed beneficiaries; and 2.) Per capita costs for beneficiaries with specific conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure). Standardized scores reflect how much a group's performance differs from the national mean performance on a measure-by-measure basis.

  All comparative cost data are risk adjusted to account for differences in patient characteristics that may affect costs. These include age, gender, Medicare eligibility status, history of medical conditions, and end-stage renal disease (ESRD) status. In addition, all comparative cost data use payment standardization to account for the differences in Medicare payments across geographic regions. The information is derived from payments for all Medicare Parts A and B claims submitted by all providers who treated Medicare fee-for-service beneficiaries attributed to a medical group practice or to a provider not affiliated with the group practice. Outpatient Part D drug costs are not included.

The QRUR categorizes Medicare patients for physicians based on the percentage of the evaluation and management (E/M) services provided by the physician to the patient in the year being used for the analysis:

- If more than 35% of the beneficiary's outpatient E/M visits went to the physician or group, that entity is said to have DIRECTED the patient's care.
- If less than 35% of the outpatient E/M visits but more than 20% of the professional costs went to the physician or group, that entity is said to have INFLUENCED the care.
- If less than 35% of the outpatient E/M visits, and less than 20% of the professional costs went to the physician or group, that entity is said to have CONTRIBUTED to the care.

Medicare Telehealth Services

Several new psychiatric services were added to the list of services that can be provided via telehealth and one was code was deleted.

Added

- CPT codes 90845 (psychoanalysis); 90846 (family psychotherapy without the patient present); 90847 (family psychotherapy with patient)
- CPT codes 99354 (prolonged service in an office or other outpatient setting; first hour list separately in addition to code for office or other outpatient evaluation and management service); and 99355 (prolonged service in the office or other outpatient setting for each additional 30 minutes (list separately in addition to code for prolonged service).

Deleted

- HCPCS code M0064 (brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders. (The APA has not supported the use of this code for several years.)

As a reminder, there are a number of conditions that must be met in order to bill for telehealth services:

- The service must be on the telehealth services list and:
    - Must be furnished via an interactive telecommunications system (defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication.)
    - The practitioner furnishing the service must meet the telehealth and Medicare requirements
    - The service must be furnished to an eligible telehealth individual (enrolled under Part B)
    - The individual receiving the service must be in a geographic location that Medicare has deemed eligible for telehealth services

Payment for Telehealth

When the above requirements are met, Medicare pays an originating site fee and provides separate payment to the distant site practitioner based on the Medicare fee schedule for the service provided.

Chronic Care Management (CCM)

CMS finalized the guidelines and established a separate payment for non-face-to-face chronic care management services provided to Medicare beneficiaries who have two or more chronic

conditions. CMS adopted CPT code 99490 and assigned a payment amount of $42.60. This service can be billed one time per month in the months when the time spent on non face-to-face care coordination services has reached 20 minutes. This is not a per-member-per-month (pmpm) payment, but rather can only be billed in months when 20 minutes or more of care coordination is provided. CMS will pay the first provider to bill this service each month (again paying only once per beneficiary per month) and requires providers to notify beneficiaries and get consent for this service prior to providing it since the beneficiary will be responsible for the copayment.

A review of the requirements and payment amount leads the APA to believe that this service is most likely to be billed by a primary care provider with an established care management program. However, psychiatrists can bill for these services if they fulfill the specific requirements. These include the establishment of a comprehensive care plan (to address both physical and mental health needs) that can be shared with others, 24/7 access to care management services, coordination with home and community based clinical service providers, and use of a certified electronic health record (an EHR that meets the certification requirements for the prior year's EHR incentive programs).

Removal of Employment Requirements for Services Furnished "Incident to" Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC) Visits

CMS removed the requirement that services furnished incident to at RHC or FQHC sites must be furnished by an employee of the RHC or FQHC, in order to allow nurses, medical assistants and other auxiliary personal to furnish "incident to" services under contract in the RHCs or FQHCs.

Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models

CMS is mandating the production of Personal Health Information (PHI) necessary to conduct statutorily mandated research regarding the Center for Medicare and Medicaid Innovation (CMMI) Grants.

Of particular note, CMS states that, "To successfully carry out evaluations, we must be able to determine specifically which individuals are receiving services from or are the subject of the intervention being tested by the entity participating in the model test." This data is needed for many purposes including the construction of control groups. There are a number of concerns, including confidentiality and lack of transparency, that will need to be monitored.

2015 List of Medicare Telehealth Services

Code	Short Descriptor
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90833	Psytx pt&/fam w/e&m 30 min
90834	Psytx pt&/family 45 minutes
90836	Psytx pt&/fam w/e&m 45 min
90837	Psytx pt&/family 60 minutes
90838	Psytx pt&/fam w/e&m 60 min
90845	Psychoanalysis
90846	Family psytx w/o patient
90847	Family psytx w/patient
90951	Esrd serv 4 visits p mo <2yr
90952	Esrd serv 2-3 vsts p mo <2yr
90954	Esrd serv 4 vsts p mo 2-11
90955	Esrd srv 2-3 vsts p mo 2-11
90957	Esrd srv 4 vsts p mo 12-19
90958	Esrd srv 2-3 vsts p mo 12-19
90960	Esrd srv 4 visits p mo 20+
90961	Esrd srv 2-3 vsts p mo 20+
96116	Neurobehavioral status exam
96150	Assess hlth/behave init
96151	Assess hlth/behave subseq
96152	Intervene hlth/behave indiv
96153	Intervene hlth/behave group
96154	Interv hlth/behav fam w/pt
97802	Medical nutrition indiv in
97803	Med nutrition indiv subseq
97804	Medical nutrition group
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99231	Subsequent hospital care
99232	Subsequent hospital care
99233	Subsequent hospital care
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99354	Prolonged service office
99355	Prolonged service office
99406	Behav chng smoking 3-10 min
99407	Behav chng smoking > 10 min
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
G0108	Diab manage trn per indiv
G0109	Diab manage trn ind/group
G0270	Mnt subs tx for change dx
G0396	Alcohol/subs interv 15-30mn
G0397	Alcohol/subs interv >30 min
G0406	Inpt/tele follow up 15
G0407	Inpt/tele follow up 25
G0408	Inpt/tele follow up 35
G0420	Ed svc ckd ind per session
G0421	Ed svc ckd grp per session
G0425	Inpt/ed teleconsult30
G0426	Inpt/ed teleconsult50
G0427	Inpt/ed teleconsult70
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel>10min
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30m
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15m
G0459	Telehealth inpt pharm mgmt

TABLE 33—SUMMARY OF FINAL CCM SCOPE OF SERVICE/ELEMENTS & BILLING REQUIREMENTS FOR CY 2015

CCM Scope of Service Element/Billing Requirement	Certified EHR or Other Electronic Technology Requirement
Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.	Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.
Access to care management services 24/7 (providing the beneficiary with a means to make timely contact with health care providers in the practice to address his or her urgent chronic care needs regardless of the time of day or day of the week).	None.
Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.	None.
Care management for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.	None.
Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. Share the care plan as appropriate with other practitioners and providers.	Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code; and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers.
Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.	Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology.
Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.	Format clinical summaries according to CCM certified technology. Not required to use a specific tool or service to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax).
Coordination with home and community based clinical service providers.	Communication to and from home and community based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record using CCM certified technology.
Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, internet or other asynchronous non face-to-face consultation methods.	None.
Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers. Document in the beneficiary's medical record that all of the CCM services were explained and offered, and note the beneficiary's decision to accept or decline these services.	Document the beneficiary's written consent and authorization in the EHR using CCM certified technology.
Beneficiary consent—Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of the calendar month) and the effect of a revocation of the agreement on CCM services.	None.
Beneficiary consent—Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.	None.